

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/09/2011	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of Complaint number IN00100128.</p> <p>This visit was in conjunction with the post survey revisit [PSR] to the Recertification and State Licensure Survey and the PSR to the investigation of complaint number IN00098540, completed on 10/31/11.</p> <p>Complaint number: IN00100128 Substantiated, No deficiencies related to the allegation are cited.</p> <p>Survey dates: December 8, 9, 2011</p> <p>Facility number: 000327 Provider number: 155561 AIM number: 100273920</p> <p>Survey team: Amy Wininger, RN TC [12/8/11] Diane Hancock, RN</p> <p>Census bed type: SNF/NF 82 Total 82</p> <p>Census payor type: Medicare 8 Medicaid 45 Other 29 Total 82</p> <p>Sample: 10</p> <p>Good Samaritan Home and Rehabilitation Center was found to be in compliance with 42 CFR part</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 483, subpart B and 410 IAC 16.2 in regard to the investigation of Complaint number IN00100128. Quality review completed 12/14/11 Cathy Emswiller RN			F 000			